BRISTOL ROYAL INFIRMARY INQUIRY

PHASE TWO

People: Education, Training, Development and Governance in the NHS

Summary Report

This is a summary report of the key points emerging from the seminar discussion on *Education, Training, Development and Governance* which took place in London on 7 March 2000.

The following were points put to the Panel in discussion; they do not necessarily reflect the views of the Panel.

Summary of the discussion

The purpose of the seminar was to consider how the professionals who provide health services are educated, trained, governed and regulated. The seminar focused predominantly on the medical profession, but took account of the experiences of other health professions, particularly nursing, and a range of professions and industries beyond health care. The seminar began by discussing the process of recruitment into medicine and the appropriateness of the selection criteria that are used. Consideration was then given to the quality and content of the undergraduate medical curriculum. There was extensive discussion of the role of continuing professional development throughout the careers of doctors after qualification. The seminar then moved on to consider the aims and organisation of professional governance, and specifically the (self)-regulation of the medical profession. There was discussion of the need for proactive as well as reactive approaches to regulation, and the seminar concluded by looking at how to prevent and deal positively with complaints. The key points emerging in each of these areas are summarised below. Many of the issues are elaborated further in position papers that were submitted in advance of the seminar and are available on the Phase 2 section of the Inquiry's website.

1. Basic medical education

1.1 *Age at entry*

(i) In the UK most applicants for medicine come straight from school at the age of 18. At present, only a minority of medical students are graduates or mature students with previous experience in other fields, although some medical schools are now beginning to offer accelerated courses for graduates. This situation contrasts with that of the US, where graduate entry to medical school is the norm. Among other professions in the UK, later entrance is more common and successful applicants tend to be those with experience and broadly based achievements in other areas. It was observed that the average age of nursing students is 27 and most managers enter the health service as graduates. Examples of later entry to professions outside the health care sector, included airline pilots, economists, lawyers and accountants.

(ii) There was widespread agreement among seminar participants that 17 or 18 may be too young an age for those assessing applicants to judge whether medicine is the appropriate career choice. At this stage, both experience and motivation are still strongly influenced by schools, teachers and parents. Those who make the decision to enter medicine at a later stage may be better able to cope with the pressures and be more committed to the profession. However, making medicine an entirely graduate entry profession may be neither practicable nor appropriate. It was suggested that there is a need for greater flexibility in career structures to make it easier to switch paths within health care, for example between nursing and medicine, and to help those who turn out to be unsuited for medicine to make constructive moves to other occupations.

1.2 *Criteria for selection*

(i) Selection for medical school has been criticised for its superficiality, being generally based on the information contained in a UCAS form and interview which, in some cases, lasts no more than 15-minutes. There is heavy emphasis on high academic achievement as measured by GCSE and A-level grades. Medical schools have been accused of elitism, lack of fairness and transparency and of not selecting from a diverse range of social and ethnic backgrounds. The criteria used for selection are not

grounded in sound evidence of what makes a good doctor. The universities handle the selection process with very little input from the wider NHS or from the public.

(ii) While not all doctors end up working directly with patients, they all spend a considerable period doing so during the training years. The general view was that doctors need not only intellectual and academic competence but also require good interpersonal skills and positive attitudes towards patients and colleagues. It was pointed out that there is evidence of a link between good communication and positive outcomes for patients and, conversely, that poor communication and failures of teamwork can lead to errors. It was suggested that current selection procedures do not take adequate account of these wider issues; that there should be wider debate both with the public and others in the NHS about what makes a good doctor; and that these constituencies should have greater involvement in determining the criteria for selecting medical students.

1.3 *Undergraduate medical education*

(i) A number of points were made about the quality and content of medical education. It was noted that (in contrast to nursing, where both a professional qualification and PGCE accredited training are standard requirements for nursing lecturers) those who teach medical students have often received no training for this role. It was also observed that medical education is embedded in tradition and is inflexible, especially where courses have been in existence for some while. However, some progress has been made in most medical schools since the publication of *Tomorrow's Doctors* by the GMC in 1993, which recommended increased attention to developing the personal and professional skills of doctors, and there are notable examples of more flexible and broadly based curricula in some medical schools.

(ii) There was discussion of the need for training and meaningful assessment in communication skills and wider competencies such as multi-disciplinary team working. It was suggested that these areas cannot be dealt with through one-off courses, but should be seen as themes which run throughout the basic curriculum and are rolled out into pre-registration and specialist training and sustained throughout consultant and GP careers.

(iii) Brief consideration was also given to the question of artificial boundaries between health care professionals and the need to think carefully about appropriate

skill mix. The idea of a generic basic education for all health care professionals was mentioned. It was seen as important to think about medical education in the context of health care as a whole, rather than as a single and separate professional pathway.

1.4 *Pre-registration training*

(i) Concerns were expressed about the difficult transition between undergraduate medicine and the pre-registration training year, when students who become house officers employed by the NHS often feel lonely, anxious and uncertain of their role. Medical schools need to ensure that students have the clinical skills that Trusts and patients require, e.g. the ability to resuscitate. Yet this alone will not ensure a comfortable transition to the work place. Comprehensive induction and continuing support in terms of one-to-one feedback are essential to help house officers cope with their new environment.

(ii) There was discussion of how young doctors who have been trained to deal with an individual patient learn to work in an organisation which has responsibility for the welfare of patients as a whole. It was acknowledged that this learning has tended to come through informal exposure through working with colleagues, rather than being explicitly addressed. It was noted that opportunities for learning from senior nursing staff have been reduced in recent years with the introduction of ward managers. It was suggested that management skills development courses at this stage might be helpful.

(iii) One problem expressed is that house officers have to 'hit the ground running' to provide the service that patients need, and there is little space provided for them to continue their own development. It was noted that those opportunities which do exist for continued training at this stage are often missed. There was general agreement that more doctors were needed and that individual development was restricted by the quantity of work expected from each doctor.

2. Continuing professional development

There was extensive discussion of the importance and benefit of continuing professional development (CPD) in medical careers. The following issues were considered:

(i) *Defining CPD*

It was suggested that CPD is something wider than the official activities that take place under this heading; that it is "not a course, but a state of mind", something that goes on all the time and is part of a learning culture. It was also pointed out that CPD can be directed to very different goals. One task is to identify and deal with the minority of individuals who are failing, another is to encourage and further develop the majority who are already competent. These purposes require quite different strategies and should not be confused. It was noted, however, that even members of the 'competent majority' do sometimes make mistakes and mechanisms are needed which will pick up on under-performance wherever it occurs.

(ii) *Appropriateness and relevance*

It was agreed that CPD needs to be both appropriate to the specific needs of the individual doctor, address the needs of the organisation and clearly associated with benefits to patient care. Concern was expressed that at present, much CPD - at least in primary care - is driven by the motivation to acquire PGEA (post graduate education allowance) points and that PGEA points can be obtained for almost any activity beyond routine clinical practice, irrespective of its value for professional development.

(iii) *Resource implications*

If greater amounts of staff time are to be spent on professional development, more staff will need to be employed. If CPD is to become another target for Trusts to work to, this will require real investment. Local Trust commitment to CPD has to be set in the context of other pressures, for example the reduction of waiting lists. If CPD is to become a priority, it needs to be recognised as such at all levels in the system. Participants heard that at any given time 15% of British Airways staff are engaged in training.

(iv) *Whose responsibility*

There was discussion about the appropriate division of responsibility for CPD between the individual professional, the Royal Colleges and the GMC. At present, the Royal Colleges are responsible for training young doctors in their respective specialties. It was suggested that College responsibilities for training should be extended to cover doctors' entire professional careers. This would give the Colleges the legal backing to make CPD programmes mandatory. There was some discussion as to whether the Royal Colleges are sufficiently in touch with issues at local level to

know what is required. It was pointed out that they have CPD advisors in every region who are actively involved in practice. The question was also raised as to whether the public have sufficient trust in the Colleges or the GMC to maintain professional standards adequately. A suggestion was made for a 'joined-up' system which ensures appropriate links are made between initiatives at different levels such as the GMC's revalidation proposals, the Royal College CPD activities and clinical governance within the NHS and also provides for lay involvement in determining standards and priorities.

(v) *Ensuring participation*

The majority of doctors take some steps to keep up to date and have done so for years, even without compulsory CPD. The question is how to engage the minority who do not. It was noted that this is a problem which arises in many professions (examples were cited of accounting, insurance and financial services) and none has solved it entirely. In professions where there is competition, this often solves the problem, as those who do not maintain their skills lose clients. There was general agreement amongst seminar participants that CPD should be compulsory. In a publicly funded health care system such as the NHS this does not apply to the same degree. An additional challenge for medicine is the enormous rate of scientific advance, which means the skill base moves on very quickly, so it is easier to become out of date.

3. Governance and self-regulation

(i) The discussion focused on the aims and organisation of professional governance and specifically on how the medical profession is (self)-regulated. It was suggested that all professions share certain core characteristics i.e. there is a body of knowledge which is deployed by practitioners, each of whom has an understanding of, and a commitment to, that body of knowledge and deals with clients who, by definition, have less knowledge of the subject than they do. Historically, professions have been self-regulating. However the structure of service delivery and the organisation of regulation varies between different professions. It was suggested that in medicine doctors behave as though they were self-employed, professing their skills with their patients and it is not entirely clear to whom they are accountable.

3.1 *Regulation of the medical profession*

(i) The medical profession has a greater degree of statutory regulation than many other professions because its regulatory body, the GMC, is distinct from its 'trade union' organisation, the BMA. In other professions these two roles are often conflated in a single organisation. The GMC has four main functions: those relating to setting standards; those around education; those involved with the maintenance of the register of practitioners; and those concerned with fitness to practice. A distinction was suggested between the regulatory task of the GMC and those areas of regulation that are more appropriately the responsibility of the employers. It was suggested that the focus of the GMC should be on clinical performance, while problems of conduct or contractual commitments should be handled by those who manage the employing organisation (although the employers may also have some role in looking at clinical performance). The GMC was described as overseeing a contract between the public and the profession. It was suggested that it must therefore undertake its regulatory function in partnership with the public. In this respect increasing the number of lay members on the GMC was seen as crucial. Participants heard that in the airline industry it is the organisation which gets the "air-operator certificate" rather than the individual. This requires the organisation to monitor itself and those it employs and enforce safety systems in order to retain the certificate.

3.2 *Principles of good regulation*

(i) The following were suggested as principles of good regulation:

* transparency (everyone knows what the rules are);
* proportionality (to risk, cost and benefits);
* accountability (people know who is responsible when things go wrong);
* good appeals procedure (and avoidance of scapegoating);
* consistency and
* targeted regulation (taking account of context of risk).

3.1 *Self-regulation*

(i) The strengths and weaknesses of self-regulation were discussed. Positive aspects were seen as:

* it is inexpensive and non-bureaucratic;

* practitioners know their own world better than outsiders can ever do;
* only those with inside knowledge can identify poor performance in a colleague and
* practitioners will have an interest in raising professional standards because this increases their own credibility.

(ii) A key problem with self-regulation is the potential for practitioners to support their colleagues and the interests of the profession against the public. Even if this is not actually the case, when things go wrong the perception of its likelihood could result in a lack of public trust.

(iii) It was suggested that self-regulation may be more viable for heavily managed and disciplined professions like nursing, where the majority of practitioners are employed in organisations and standards are often implemented by employers, than for less obviously managed professions such as medicine and dentistry.

3.3 *State regulation*

(i) An alternative to self-regulation of professions is state regulation, either through prescriptive legislation or through simple legislation accompanied by codes of practice.

(ii) State regulation was also regarded as having some disadvantages. These included that it is risk averse and slow. It was also pointed out that the state is not a neutral stakeholder and can be captured by the industry it is regulating. So, in reality, the distinction between state and self-regulation may not always be entirely clear. Both state and self-regulatory processes can be completely closed and opaque to those outside, or more open. The more open ones are more expensive but preferable, because they involve scrutiny of those who are regulated and of the regulators and are ultimately more efficient and effective. Participants noted that more complex regulation models exist, eg, self regulation via external elements.

3.4 *Views about the future*

A number of views were expressed about the present strengths and weaknesses of the regulatory system in medicine, what is the appropriate measure of professional involvement, and the prospects for change.

(i) Seminar participants heard the view that there should be generic standards for those professions who wish to maintain self-regulation. The professions involved could be given a period of time in which to meet all standards, they would then be audited, and if the standards had not been achieved then the right to self-regulate would be taken away and some other mechanism developed. In medicine, the biggest difficulty has already been overcome through the separation of the BMA and the GMC. However, a survey undertaken by the Consumers' Association of members of the public who had made complaints against doctors makes it clear that there are still some major flaws in the system. One particular issue is that a doctor can opt out of the disciplinary procedures by retiring, but it was noted that regulations are now being changed to remove this option. Another is that complainants have no right to see the doctor's written submission in defence. It was noted that when these research findings were presented to the GMC, they were welcomed and had generated a very constructive dialogue.

(ii) It was pointed out that there are legal constraints on the GMC which are not widely acknowledged or understood. For example, interim suspension is not possible by law, although it has often been asked for. Equally, there have been changes in recent years. Participants heard that the GMC is now assessing poorly performing doctors by peer review, and they are being removed from the register or suspended because of poor performance. It was suggested that the Council has damaged itself by not publicising certain aspects of its work. That, combined with a slow, bureaucratic, hidebound response and inadequate legislation - which does need reform – leaves a mixed picture of the GMC's activities.

(iii) It was observed that, in contrast to the area of medical education, where the GMC has been very proactive in initiating and leading change, with regard to fitness to practice issues it has remained essentially reactive. However, this is now changing, in part because of the increasing lay membership, and there is said to be a great desire for change within the GMC. The point was made that before a decision is made about the future of the GMC, it is important to ensure that any alternatives are carefully considered. A plea was made for looking carefully at whether modernisation of the GMC, increasing its lay membership still further and widening its legal powers through parliament might be the better option. The key decision to be made is on the balance between self-regulation with significant external influence, the current

preferred route, or external regulation with significant medical influence, which is, as yet, untried.

(iv) Attention was drawn to the new statutory duty of NHS employers for quality, which means that managers must be concerned with standards of clinical performance as well as conduct and behaviour. There is confusion at present between the role of the employer in this area and that of the regulatory body in determining whether the practitioner is fit to practice at all. It was noted that there is a need for equity between staff, which is undermined at present by the fact that employers may discipline a nurse, but are unable to use the same authority to discipline a doctor.

4. Preventing and dealing with complaints

Discussion focused on proactive approaches to encouraging, identifying and learning from complaints.

4.1 *Preventing problems arising*

(i) A distinction was drawn between the role of the professional regulatory mechanism and the role of local organisations in dealing with complaints. As an example of the former, seminar discussants heard about the role of the United Kingdom Central Council for Nursing Midwifery and Health Visiting (UKCC). The UKCC deals only with the most serious complaints, which are likely to lead to someone being removed from the register. The point was made that the UKCC relies for the avoidance of complaints on the quality of education and the way that professional values are inculcated. The UKCC publishes the lessons learned from complaints that have been made, feeding them back appropriately to encourage local employers to improve their own preventative procedures (for example, ensuring that the registration of new employees is checked and that their references are properly taken up). It was suggested that this iterative process from the regulatory body through to the profession is very important.

4.2 *Identifying and understanding problems*

(i) Seminar participants heard about the arrangements for monitoring performance in the airline industry, where every incident and near incident is logged, and any facet of an aircraft, airfield or individual crew member's performance can be studied. Whenever a serious problem is identified or an unexplained serious incident occurs, the whole team is suspended immediately without prejudice until the cause of

the incident has been identified. There is a no blame culture except in respect of non-declaration of incidents. Problems identified in translating this approach to the environment of health care include the fact that potential problems are harder to measure and identify and suspending the team responsible for a problem may be both impractical and stigmatising. The importance of incorporating systems within which the importance of consistent critical incident reporting is recognised and where professionals can come forward without fear, was noted. Suspension is not part of the culture and the perception tends to be that someone would not be suspended unless there were strong suspicions against them.

(ii) There was discussion of the National Confidential Enquiry into Peri-Operative Deaths (NCEPOD). This was set up as a confidential and voluntary exercise, with the purpose of looking at all such deaths to see what lessons might be learned. NCEPOD has been helpful in effecting change, for example it has reduced the amount of out-of-hours operating sessions. However, there is still a small element of non-cooperation amongst practitioners. A key reason for this is the unavailability of appropriate medical records. It was suggested that medical records do not go missing randomly, and that in general it is essential to collect information regularly and routinely across the board, and not just from co-operating clinicians.

(iii) It was emphasised that there are a variety of ways of accessing valuable information about quality which do not depend upon sophisticated data systems or formal processes. These include: (a) utilising information that is available from a variety of sources (for example the Ombudsman's report, Audit Commission reports and national inquiries) to identify potential lessons; (b) going directly to the ward or department where complaints have arisen and trying to understand the problem in its context, rather than depending solely on the bureaucratic process.

4.3 *Encouraging and welcoming complaints*

(i) Various factors were identified which may militate against members of the public making legitimate complaints. These include:

* uncertainty as to whether it is reasonable to complain;
* not wanting to rock the boat or get people into trouble and
* finding the process too difficult and unwieldy.

Participants agreed that it was important to open up many more routes for patients to give feedback on their experience of care. Such a process could help to identify

problem areas before more serious complaints arise. It could also provide useful "intelligence" on how to improve the quality of patients' experience and thus be good for the public image of an organisation i.e. caring. With regard to complaints it was suggested that what the public needs is a single booklet (or website) that explains the distinct roles of the different bodies such as the Trust itself, the GMC or the Ombudsman, and indicates how each sort of complaint or problem should be pursued.

(ii) It was noted that the Public Interest Disclosure Act now gives protection for anyone working in the NHS (or any public service) to raise concerns legitimately. The GMC has also laid out a duty for doctors to raise concerns about under-performing colleagues. But it was highlighted that there is still a need for an independent presence, perhaps a whistle-blower's advocate who is trusted by all parties.

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